Back In Harmony Chiropractic and Wellness Center, LLC

6115 Stirling Rd., Suite 205 • Davie, FL 33314 • Tel: 954-604-5394 • Fax: 954-440-2471

Welcome to our clinic!

You are important to us and we thank you for your trust.

REGISTRATION FORM

(Please Print)

PATIENT INFORMATION

Patient's last name: First: Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Street address:	Birth date: / /	Age:	Sex: ❑ M ❑ F	
City: State: ZIP Code:	Social Security no.:	Home phone no.: ( )		
Email address:	Cell phone no: ( )			
Occupation:	Employer Name and Address:	Work phone no.: ( ) Ext		
Spouse name:	Family physician:			
	Address: Tel:			
Whom may we thank for referring you?				

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )
Is this person a patient here? ❑ Yes ❑ No			
Insurance Company:			
Subscriber's name:	Subscriber's S.S. #:	Birth date: / /	Group no.: Policy no.:
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other			
Is patient covered by additional insurance? ❑ Yes ❑ No			
Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other			

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone no.:	Work phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Back In Harmony Chiropractic and Wellness Center, LLC or insurance company to release any information required to process my claims.

Patient/Guardian signature _____ *Date* _____

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PATIENT INTAKE FORM

Name:_____ Date _____

Please describe your major complaints/symptoms: _____
_____
_____

Is your current problem the result of: Auto Accident? Work Accident? Slip & Fall?

When did this start? _____

What caused the pain? _____

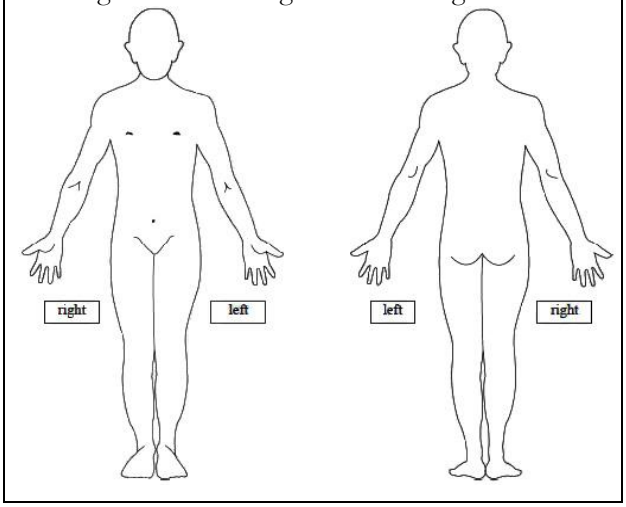
How often are your symptoms present?
☐ Constantly ☐ Frequently ☐ Occasionally ☐ Intermittently

Describe your current pain/symptoms:
☐ Sharp/Stabbing ☐ Burning ☐ Throbbing ☐ Shooting
☐ Tingling ☐ Stiffness ☐ Dull ☐ Numbness ☐ Soreness
☐ Aches ☐ Weakness ☐ Swelling ☐ Heavy Pressure
☐ Other (please describe)_____

Please rate the severity of your pain:
☐ Mild ☐ Moderate ☐ Severe ☐ Intolerable

Does this pain travel to any other area? If yes, where? _____
_____

Please mark the area of discomfort below.
Pain XXXX Numbess OOOO
Pins&Needles////
Burning ++++ Aching - - - - Stabbing VVVV



What makes this pain better? ☐ Nothing ☐ Lying Down ☐ Standing ☐ Walking ☐ Sitting ☐ Movement
☐ Exercise ☐ Inactivity/Rest ☐ Heat ☐ Ice Massage Pain Killers ☐ Other

What makes this pain worse? ☐ Nothing ☐ Lying Down ☐ Standing ☐ Walking ☐ Sitting ☐ Movement
☐ Exercise ☐ Inactivity/Rest ☐ Heat ☐ Ice ☐ Massage Other

Since it began, is your problem: ☐ Improving ☐ Getting Worse ☐ No Change

Does this interfere with your: ☐ Work ☐ Sleep Daily Routine ☐ Recreation

Describe your job requirements: ☐ Mainly Sitting Light Labor ☐ Heavy Labor ☐ Standing
Have you lost any work? ☐ Yes ☐ No Day and date you last worked _____

Have you had: ☐ pain that wakes you out of a sound sleep?
☐ any changes in bowel or bladder habits?
☐ night sweats?
☐ lost or gained weight in the past year?

What else have you done to treat this pain? _____
Have you ever had chiropractic care before? ☐ Yes ☐ No Dr's name_____
Last adjustment _____Were the results satisfactory? ☐ Yes ☐ No ☐ N/A
Have you ever had this condition before or a similar condition? ☐ Yes ☐ No When? _____
Date of last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____
MRI, CT, Ultrasound, Bone Scan _____Chest X-Ray _____ Urine Test _____

Symptom Survey

Please "check" the symptoms or conditions you experience frequently:

Sp/St	Ht/P	Lu/LI	Ki/UB	Liv/GB
__ excessive appetite	__ insomnia	__ cough	__ low back pain	__ eye problems
__ loose stool/diarrhea	__ palpitations	__ shortness of breath	__ knee problems	__ jaundice
__ digestive problems, indigestion	__ cold hands and feet	__ decreased sense of smell	__ hearing impairment	__ difficulty digesting oily foods
__ vomiting	__ nightmares	__ nasal problems	__ ear ringing	__ gall stones
__ belching, burping	__ mentally restless	__ skin problems	__ kidney stones	__light-colored stool
__ heartburn/reflux	__ laughing for no reason	__ claustrophobia	__ decreased sex drive	__ soft or brittle nails
__ stomach bloating	__ chest pains	__ colitis/diverticulitis	__ hair loss	__ easily angered
__ obsession in work,	__ poor memory	__ constipation	__ urinary problems	__ difficult relationships
__ blood in stool	__ sadness	__ allergies	__ dental problems	__ difficulty making decisions
__ lack of appetite	__ Depression	__asthma	__ fatigue	__ dizziness
__ hemorrhoids	__ Anxiety	__ get sick easily	__edema	__headaches
__easily bruised				
__ I usually feel warm	__ I usually feel chilled			

Please indicate if the following pertain to you:
NOTE: This Symbol ♀: before a question, indicates that it is for Women only.

Kidney Yin Xu-	**Kid Yang Xu-**
□ Do you have lower back weakness, soreness or pain?	□ Is your back sore or weak?
□ Do you have ringing in your ears?	□ Are your feet cold, especially at night?
□ Is your hair prematurely gray?	□ Are you typically colder than those around you?
□ Do you have dark circles under your eyes?	□ Is your libido low?
□ Do you have night sweats?	□ Are you often fearful?
□ Are you prone to hot flashes?	□ Do you wake up at night or early in the morning because you have to urinate?
□ Would you describe yourself as "afraid" frequently?	□ Do you urinate frequently, and is the urine diluted and/or profuse?
□ Do you have dizziness?	□ Do you have early morning loose, urgent stools?
□ Do you have knee problems?	□ ♀: Do you have low back pain pre-menstrually?
□ ♀: Do you have vaginal dryness?	□ ♀: Do you have profuse vaginal discharge?
□ ♀: Is your mid-cycle cervical mucus scanty or missing?	□ ♀: Do you feel cold cramps during your period that respond to a heating pad?

Spleen Qi – Xue – Yang Xu

□ Are you often fatigued?

□ Do you have poor appetite?

□ Is your energy low after a meal?

□ Do you feel bloated after eating?

□ Do you crave sweets?

□ Do you have loose stools, abdominal pain, or digestive problems?

□ Are your hands and feet cold?

□ Are you prone to feeling sluggish?

□ Are you prone to heaviness or grogginess in the head?

□ Do you have varicose veins?

□ Are you prone to worry?

□ Have you been diagnosed with low blood pressure?

□ Do you sweat a lot without exerting yourself?

□ Do you feel dizzy or light-headed, or have visual changes when you stand up fast?

□ Are you often sick, or do you have allergies?

□ Have you ever been diagnosed with hypothyroid or anemia?

□ Do you have hemorrhoids or polyps?

□ ♀**:** Is your menstruation thin, watery, profuse, or pinkish in color?

□ ♀**:** Are you more tired around ovulation or menstruation?

□ ♀**:** Do you ever spot a few days or more before your period comes?

□ ♀**:** Have you ever been diagnosed with uterine prolapse?

□ ♀**:** Are your menstrual cramps accompanied by a bearing down sensation in your uterus?

Blood Xu-

□ Do you have dry, flaky skin?

□ Are you prone to getting chapped lips?

□ Are your fingernails or toenails brittle?

□ Is your hair brittle or dry?

□ Do you have diminished nighttime vision?

□ Are your lips, the inner side of your lower eyelids, or tongue pale in color?

□ ♀**:** Do you get dizzy or light-headed around your period?

□ ♀**:** Are you losing hair on your head?

□ ♀**:** Are your menses scant or late?

Blood Stasis

□ Do you experience periodic numbness of your hands and feet, especially at night?

□ Do you have varicose or spider veins?

□ Do you have red cherry spots (hemangiomas) on your skin?

□ Do you have chronic hemorrhoids?

□ Do you have dark spots in your eyes?

□ Have you been diagnosed with any vascular abnormality or blood clotting disorder?

□ ♀**:** Does your menstrual blood contain clots?

□ ♀**:** Have you been diagnosed with endometriosis or uterine fibroids?

□ ♀**:** Do you have piercing or stabbing menstrual cramps?

□ ♀**:** your menstrual flow ever brown or black in color?

□ ♀**:** Do you feel mid-cycle pain around your ovaries?

□ ♀**:** Do you have painful, unmovable breast lumps?

Liver Qi Stagnation

□ Are you prone to emotional depression?

□ Are you prone to anger and/or rage?

□ Are your pupils usually dilated and large?

□ Do you have difficulty falling asleep at night?

□ Do you experience heartburn or wake up with a bitter taste in your mouth

□ ♀**:** Do you become irritable pre-menstrually?

□ ♀**:** Do you feel bloated or irritable around ovulation?

□ ♀**:** Does it feel as if your ovulation lasts longer than it should?

□ ♀**:** Are your breasts sensitive/sore at ovulation?

□ ♀**:** Do you experience nipple pain or discharge from your nipples?

□ ♀**:** Do you have a lot of pre-menstrual breast distension or pain?

□ ♀**:** Do you become bloated pre-menstrually?

□ ♀**:** Are your menses painful?

□ ♀**:** Do you feel your menstrual cramps in the external genital area?

□ ♀**:** Is your menstrual blood thick and dark, or purplish in color?

Heart-

□ Do you wake up early in the morning and have trouble getting back to sleep?

□ Do you have heart palpitations, especially when anxious?

□ Do you have nightmares?

□ Do you seem low in spirit or lacking vitality?

□ Are you prone to agitation or extreme restlessness?

□ Do you fidget?

□ Do you sweat excessively, especially on your chest?

Excess Heat

□ Are your mouth and throat usually dry?

□ Are you often thirsty for cold drinks?

□ Do you often feel warmer than those around you?

□ Do you wake up sweating or have hot flashes?

□ ♀**:** Do you breakout with red acne, especially pre-menstrually?

□ ♀**:** Do you have a short menstrual cycle?

□ ♀**:** Do you have vaginal irritation?

Dampness

□ Do you feel tired and sluggish after a meal?

□ Do you have cystic or pustular acne?

□ Do you have urgent, bright, or foul-smelling stools?

□ Are you overweight?

□ Do you have a wet, slimy tongue?

□ Does your body feel like a barometer? Can you sense when it will rain?

□ ♀**:** Does your menstrual blood contain stringy tissue or mucus?

□ ♀**:** Are you prone to yeast infections and vaginal itching?

□ ♀**:** Do you have fibrocytic breasts?

♀For Women

Age of first period _____ Date of last period _____ Number of children (live births) _____

Number of days between periods (your cycle) _____Number of days of flow_____

♀ Check All that Apply:

Color of flow: □ pale/light red □ red □ bright red □ dark red □ dark red/brown □ dark red/purple
# of pads you use per day:
Pain and Cramping: □ No / □ Yes □ mild □ moderate □ severe
1st day ___2nd day __3rd day ___4th day ___Before flow ___After flow
Amount of flow:
□ even throughout
□ clots □ No / □ Yes 1st day ___2nd day __3rd day ___4th day ___Before flow ___After flow
□ spotting □ No / □ Yes 1st day ___2nd day __3rd day ___4th day ___Before flow ___After flow
□ light □ No / □ Yes 1st day ___2nd day __3rd day ___4th day ___Before flow ___After flow
□ heavy □ No / □ Yes 1st day ___2nd day __3rd day ___4th day ___Before flow ___After flow

Other symptoms related to menses: □ Discharge □ PMS □ Headache □ Nausea □ Constipation

□ Diarrhea □ Swollen Breasts □ Mood Swings □ Increased Appetite □ Decreased Appetite □ Insomnia

Have you ever been diagnosed with: □ Fibroids □ Fibrocystic breasts □ Endometriosis □ Ovarian cysts □ PID □ Polycystic ovary syndrome □ STD _____

Fertility Information

of IVF procedures_____ # of IUI procedures_____

Has a physician diagnosed a difficulty with fertility due to: □ Female Factor □ Male Factor □ Unexplained

□ Other _____

AUTHORIZATIONS AND RELEASES

Back In Harmony Chiropractic and Wellness Center, LLC • 6115 Stirling Rd, Suite 205, Davie, FL 33314 • 954-604-5384

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices.

Patient Signature _____ Date _____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I hereby authorize _____ to disclose to Back In Harmony Chiropractic and Wellness Center, LLC. or their agent, any information which they may have acquired by history, examination or other means of my physical and/or mental condition and I hereby release them of any consequences thereof.

Patient Signature _____ Date _____

AUTHORIZATION FOR RELEASE OF RECORDS AND X-RAYS

Pursuant to appropriate statues and rules. I hereby authorize and request that you release and forward copies of any and all health records in your possession, including x-rays to:

_____
Physician

_____
Address

_____
City State Zip

Patient Signature _____ Date _____

VERIFICATION OF NON-PREGNANCY (FEMALE PATIENTS ONLY)

By my signature on this form, I do hereby state that, to the best of my knowledge, I am **NOT** pregnant, nor is pregnancy suspected or confirmed at this particular time. I further agree and release Dr. Chong and her staff from any responsibility for injury or complication to myself or my fetus should I be pregnant on this date.
I further agree to notify this office in writing during the course of my treatment should I become pregnant.

Patient Signature _____ Date _____

ASSIGNMENT OF INSURANCE BENEFITS

I hereby direct and instruct the _____ insurance company to pay by check made payable and mailed directly to: **Back In Harmony Chiropractic and Wellness Center, LLC.**
6115 Stirling Rd, Suite 205, Davie, Florida 33314
If this policy prohibits direct payment to doctor, then I hereby also direct and instruct you to make checks payable to me and mailed as follows: **C/O: Back In Harmony Chiropractic and Wellness Center, LLC.**
6115 Stirling Rd, Suite 205, Davie, Florida 33314
The professional or medical expense benefits allowable and otherwise payable to me under my current policy as payment toward the total charges for professional services rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.** This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize Dr. Wei Sheen Chong to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

A photocopy of this Assignment shall be considered as effective and valid as the original.

Patient Signature _____ Date _____

Informed Consent for Chiropractic and Acupuncture Treatment

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

Acupuncture involves the insertion of needles through the skin at specific points on the body in order to restore the flow of Qi (Life force/energy) and alleviate pain. Additional supportive procedures can include moxibustion, cupping and gua sha/scraping.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, sprains, bruising, numbness and tingling near the needling sites that may last a few days, dizziness, and fainting. With respect to strokes, there is a rare but serious condition known as a cervical arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. This occurs in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke. As chiropractic can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments.

Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk and burns and/or scarring are a potential risk of moxibustion.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date: _____

PATIENT NAME:

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process, except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. Further, the parties will not have the right to participate as a member of any class of claimants, and there shall be no authority for any dispute to be decided on a class action basis. An arbitration can only decide a dispute between the parties and may not consolidate or join the claims of other persons who have similar claims.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, as to whether this agreement is unconscionable, and any procedural disputes, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider, including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers, preceptors, or interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days, and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction, or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and, if not revoked, will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment), patient should initial here. _____. Effective as of the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

(Date)

PATIENT SIGNATURE **X**

(Or Patient Representative) (Indicate relationship if signing for patient)

(Date)

OFFICE SIGNATURE **X**

Back In Harmony Chiropractic and Wellness Center

OFFICE FINANCIAL POLICY

Professional Fee Schedule

Chiropractic Initial Consultation/Examination ..... $115-$225
X-Rays..... $50 and up
Chiropractic Office Visits..... $45 and up

Acupuncture Initial Consultation.....$115
Acupuncture treatments.....$70

All fees are standard and based on our professional association's guidelines for our geographic area.

Our experience has shown that it is wise to have an understanding with our patients as to our office policies and fees. This form has been prepared for your convenience and information. We offer several methods of payment for your Chiropractic Care at our office, and you may choose the plan that best fits your needs. Please read carefully and choose the plan which you prefer. This information will enable us to better serve you and help avoid misunderstandings in the future. If special arrangements are necessary, please consult with the Doctor. Our main concern is your health and well-being, and we will do our best to help you.

(Check One)

( ) **PLAN #1 HEALTH INSURANCE:** If you have health insurance that covers Chiropractic care, we will bill your insurance directly and expect to be reimbursed by your insurance company. Please be aware that payment from your insurance company cannot be guaranteed, and benefits are not determined until your claim is processed. Until we have the completed, necessary insurance information to verify chiropractic coverage, you will be required to pay for your care. Our staff will collect any applicable deductible, co-payments, patient responsibilities and any charge for non-covered services from you at the time of service. In the event the check should come to you, you are expected to bring the check to us.

( ) **PLAN #2 CASH AGREEMENT:** This option is for those that do not have insurance or choose not to use their insurance. This is a fee-for-service option and full payment is due at the time services are rendered. We accept cash, check, Visa, Mastercard and Discover. If you do not have coverage for chiropractic care you may want to consider joining ChiroHealth USA, a Discounted Medical Plan Organization. Inquiries can be made at the front desk.

( ) **PLAN #3 CHIROHEALTH USA:** We have joined Chirohealth USA to enable us to keep visits affordable for those that are uninsured or underinsured for chiropractic care. This is a Discounted Medical Health Plan which allows us to offer a discounted fee for non-covered services. Annual membership is $49 and covers you and your immediate family.

( ) **PLAN #4 "ON THE JOB" INJURY:** Worker's Compensation pays in full for chiropractic care. Upon being released from care, a three month time period is allowed for settlement of your claim. If settlement has not been reached within this time period, or you have suspended or terminated your care without your doctor's approval, payment for services is due immediately. I understand that I am being treated under the assumption that this injury is work-related. In the event that this case proves not to be work-related or denied, then I am fully aware of the charges incurred to me and I am also aware that I am fully responsible for the charges.

( ) **PLAN #5 AUTO-INJURY:** We will bill your insurance directly after verification of coverage. Most patients have either Medical Payments coverage or an attorney or both. If you hire an attorney to represent you, it is our policy to have your attorney sign a Doctor's Lien. This will guarantee direct payment to our office for any unpaid balance upon the settlement of your lawsuit. **Upon being released from care, a three month time period is allowed for settlement of your claim. If settlement has not been reached within this time period, or you have suspended or terminated your care without your doctor's approval, payment for services is due immediately.**

We hope that this has answered any questions that you might have about our financial arrangements. If at any time you have further questions about your care, please do not hesitate to ask us.

I have read and understand the above terms.

Patient Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

Back In Harmony Chiropractic and Wellness Center, LLC. • 6115 Stirling Rd, Suite 205, Davie, FL 33314 • 954-604-5384

PLEASE KEEP FOR YOUR RECORDS

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

Back In Harmony Chiropractic and Wellness Center, LLC is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay
your health care bills, to support the operation of the physician's practice, and any other use required by law.
Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.
Payment: We may disclose your health information to your insurance provider for the purpose of payment or health care operations. If you are covered by a medical plan, our office will bill the insurance company; the claim form will contain information that identifies you, your diagnosis, and the treatment you received.
Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of business associate, licensing, and conducting or arranging for other business activities. For example, a physician treating you for a condition or disease may need to know the results of your latest physician examination by this office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment or other health-related services that may be of benefit to you.
We may use or disclose your protected health information in the following situations without your authorization. These situations include: Public Health issues as required by law, Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners, Funeral Directors and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers' Compensation.
Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.
Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. We do not provide patient information to other organizations.
Change of Ownership: In the event that Back In Harmony Chiropractic and Wellness Center, LLC. is sold or merged with another organization, your health information/records will become the property of the new owner.

Your Health Information Rights:

- You have the right to inspect and copy your protected health information.
- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that Back In Harmony Chiropractic and Wellness Center, LLC. is not required to agree to the restriction that you requested. If physician believes it is in your best interest to permit use and disclosure of

your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

- You have the right to inspect and copy your health information.
- You have a right to request that Back In Harmony Chiropractic and Wellness Center, LLC. amend your protected health information. Please be advised, however, that Back In Harmony Chiropractic and Wellness Center, LLC. is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by Back In Harmony Chiropractic and Wellness Center, LLC.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices: We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Complaints: Complaints about your privacy rights can be made in writing to:

Attn: Office Manager
Back In Harmony Chiropractic and Wellness Center, LLC.
6115 Stirling Rd, Suite 205
Davie, FL 33314

If you are not satisfied with the manner in which our office handles your complaint, you may submit a formal complaint to the Department of Health and Human Services:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, D.C. 20201